Reflection

The Model of Professional Thinking (see appendix 1, Bannigan & Moores, 2009) integrates reflective and evidence based practice to facilitate review and development of services. The following event causing curiosity, anxiety and worry was analysed utilising this method to guide behaviour in future challenging experiences.

Stage 1: What?

Observed first shower assessment with 86yo female patient with dementia on an aged care and rehabilitation ward. Shower task analysis also completed prior to the assessment to understand the process and purpose of conducting a shower assessment.

Stage 2: So What?

2a: Critical analysis of the event.

Prior to assessment, I felt anxious regarding client privacy. I felt worried about being intrusive however informed consent was gained as the client was positive about the assessment. I felt incompetent as a second year student due to a lack of training with shower assessments, however, this anxiety was eased with consent, guidance and positive communication. Being a new experience, adopting a clear observant role allowed me to observe the occupational therapist's role and professional standards for shower assessments. Although task analysis enhanced my understanding, I felt unsure of where and at what times during the assessment it was appropriate to look in certain areas e.g. cleaning or drying perineum or chest.

What went well.

There were no manual handling or client safety incidents and the therapist conducted the assessment appropriately and safely. By adopting an observant role, I wasn't posing any health and safety risk to the client nor did I impose on their privacy. Although diagnosed with dementia, the client did express awareness of safety precautions. Upon standing, the client initiated the use of safety rails and reported "I need to hold on to these to be safe."... "these will stop me from falling over". The client also utilised the shower chair that was in place in order to manage her fatigue by independently preserving energy for drying and mobilising tasks.

What I did well:

I maintained concentration on the task and adhered to requests by the therapist to remove the walker from the room to create more space and handing the client toiletry items required for the assessment. Although the client gave consent to my participation, I maintained distance to alleviate intrusion or discomfort for the client.

What others did well:

The therapist prompted the client to perform tasks both safely and independently. As reported by the client, on the rehabilitation ward the nursing staff performed tasks for the client including: washing, manual handling enabling client to stand and drying legs, feet and in between her toes. However, due to the focus of the profession, the therapist gave the client opportunities to perform these tasks and consequently enable independence.

What went wrong:

A significant health and safety risk includes the lack of water drainage and flexibility of the hand-held shower hose. Easy manoeuvrability and decreased awareness caused excess water flooding the floor and becoming a falls risk during transfers and when mobilising.

Step 2b: Seeking and reviewing knowledge

From this event, I posed the following questions:

- "Is there evidence to support student education of shower analysis and assessment?"
    - Glenn, & Gilbert-Hunt (2012): limited educational exposure in current student education.
- "Is there evidence to support the use of equipment within a rehabilitation setting?"
    - Lord, Sherrington & Close (2007): equipment prevents falls risk in home and rehabilitation

      Seton & Bridge (2006): improvements in functional transfer performance of elderly using a grab rail
    - Schemm & Gitlin (1997): interaction, cues and support enable idependent client use of equipment
    - Koval & Kooley (2005): identify effectiveness of equipment to optimise functional performance

Step 2c: Initial ideas and sharing

Initial findings indicate limited evidence to support student education in regards to shower analysis and assessment due its complex nature (Glenn, &

Gilbert-Hunt, 2012). This has a significant impact on learning and professional experiences as this phenomological study identifies that new graduate occupational therapists lack the skills and confidence to conduct shower assessments. In relation to equipment provision in rehabilitation, the findings indicate evidence to support its use in order to prevent falls and increase both functional performance and independence with self-care tasks during admission (Lord, Sherrington & Close, 2007; Seton & Bridge, 2006; Schemm & Gitlin, 1997; & Koval & Kooley, 2005). These findings were discussed with my supervisor who attempted to challenge my conclusions to enhance my understanding and clinical reasoning.

Stage 3: Now what?

Evidently, more research and training needs to be implemented regarding student education. However, based on client and environmental context, equipment provision strongly is supported to facilitate self-care independence in a rehabilitation setting. Changes in this practice would be elicited by individual functional performance, capabilities and need for assistive devices in rehabilitation.

In conclusion, Kolb's Experiential Learning Theory (Kolb, Boyatzis, & Mainemelis, 2000) is a model of professional thinking most commonly applied in health settings (Titiloye & Scott, 2001). Although individuals must adapt to apply the skills of each four learning modes, no single environment orientates towards one learning style (Kolb, 1984). In the rehabilitation setting I adopted a converger learning style encompassing abstract conceptualisation and active experimentation. As a converger, I utilised deductive reasoning, problem solving and decision making skills to guide the occupational therapy process. However, Kolb and Wolfe (1981) identified certain professions can create environmental pressures in which

individuals must adopt a particular learning style. Consequently, research has ascertained that the common preferred learning styles of occupational therapy students are convergers and assimilators. As a converger, the following learning strategies have been evaluated:

Evaluation of Learning Strategies

Successful	Unsuccessful
1. Researching and understanding assessment prior to completion	1. Asking questions prior to completing individual research
2. Researching diagnoses and appropriate treatment plans	2. Maintaining observatory role
3. Observation of procedures to inform student understanding	3. Differing supervisor and student learning styles
4. Critical reflection on practice weekly	4. Unstructured supervision sessions
5. Taking initiative to complete individual projects	
6. Asking appropriate questions regarding procedures, clients and the context	
7. Supervisor-student discussions and feedback regarding clinical practice	
8. Researching valid and reliable interventions to guide practice	

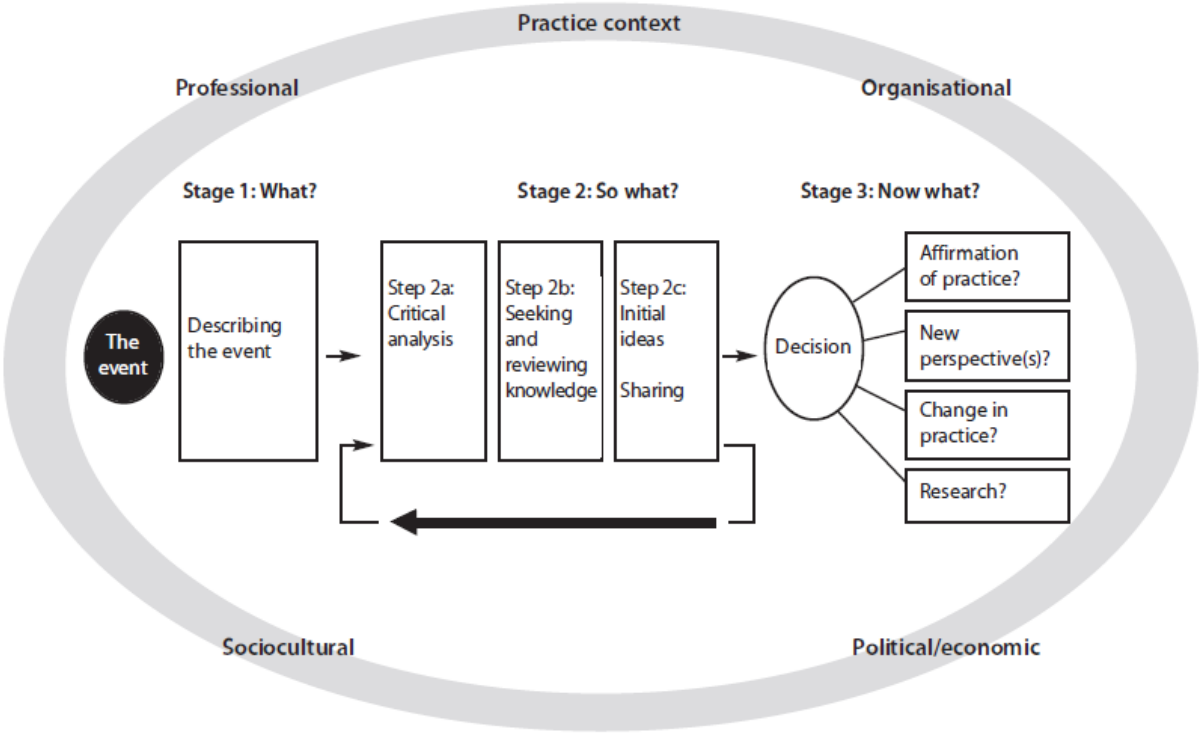
From this placement, the most effective strategies for lifelong learning include successful strategies 1-8. These ensure thorough clinical knowledge of the practice

process and facilitate critical reflection, a key concept of professional practice (Delany, & Molloy, 2009). As a future occupational therapist I have learned the benefits of:

- clinical reflection to guide practice
- assertive and motivated attitudes to practice
- understanding individual learning styles to facilitate effective learning strategies
- feedback to facilitate performance improvements
- initial task observation to facilitate understanding
- personal research to enhance clinical understanding.

From placement, however, I learned to avoid integrating personal and professional life, to respect individual values and attitudes and maintain an enthusiastic and diligent approach to practice as a future occupational therapist.

Appendix 1.



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